SOUTH DAKOTA state employee benefits program learn. act. thrive.

Application to Continue Benefits--COBRA South Dakota State Employee Benefit Program 500 East Capitol Avenue Pierre, SD 57501-5070 Phone: 1.877.573.7347, option 2

Fax: 605-773-6840 http://benefits.sd.gov

| Name: | SS | N or Insurance ID: | |
|--|-------------------|--|-------------------------------|
| Last First | MI | | |
| Mailing Address: | | | |
| Street | City | St | ate Zip Code |
| Date of Birth:/ Phone: | | _Email: | |
| I am: □ a former employee □ a participating If you are a participating family member, please | | | on: |
| Name: | Emp. Soc. Sec. No | | |
| 2) ☐ I DO elect continuation coverage. You must also complete the Direct Payme | ent Plan form a | nd attach a voided chec | k with your application. |
| ☐ I DO NOT elect continuation coverage. (Ple | ase complete th | e information above, sign | and return this form.) |
| 3) Participant and/or dependent informatio | n for each pe | son who will be conti | nuing coverage: |
| Name B | irth Date | Soc. Sec. No. | Which Plan(s)? |
| | | | |
| | | | |
| | | | |
| · | | | |
| 4) I request continuation coverage for the f | • • | • | |
| ☐ Health Plan | | I Medical Flexible Spendi I Dental Plan | ng Account |
| ☐ Low Deductible Health Plan (\$850)☐ High Deductible Health Plan (\$1,800/ | | | |
| ☐ Fight Deductible Health Plan (\$1,600/ | φ3,600 <i>)</i> | ☐ Base Plan | |
| | - | ☐ Enhanced Plan | |
| | L | I Vision Plan | |
| 5) Non-tobacco User or Tobacco User? | | | |
| ☐ I am not a tobacco user | | My covered spouse is n | ot a tobacco user |
| ☐ I am a tobacco user | | My covered spouse is a | tobacco user |
| 6) Which qualifying event(s) make you elig | ible for contin | uation coverage? | |
| ☐ Employee Termination | | Divorce or Legal Separa | ation |
| ☐ Employee Death | | Receiving Coverage Un | |
| ☐ Reduction of Employee's Hours | | Disabled Employee | dei Medidare |
| ☐ Child is Ineligible to be Covered | | Retired Employee* | |
| as a Dependent | _ | * Watch for Retiree Enrollr | nent forms coming soon. |
| · | | | · · |
| I represent that the foregoing information is, to the <i>k</i> I (we) must abide by the Plan's provisions. | best of my knowl | edge and belief, accurate. | I agree that to retain covera |
| A . W | | | |
| Applicant Signature BHR Form COBRA | | Date Signed | REV 04/17 |

SOUTH DAKOTA STATE EMPLOYEE HEALTH PLAN FY18 PLAN YEAR

July 1, 2017 - June 30, 2018

| FY18 COBRA MONTHLY CONTRIBUTION RATES | | | | |
|---------------------------------------|----------------------------|---|--|--|
| Coverage Level | Low Deductible Health Plan | High Deductible Health Plan (HSA Compatible) | | |
| Participation Only | \$585.76 | \$549.05 | | |
| Participant + Spouse | \$1,265.10 | \$1,185.41 | | |
| Participant + Child(ren) | \$899.92 | \$845.30 | | |
| Family | \$1,578.64 | \$1,481.04 | | |

^{*\$60} per person, per pay period will be added to your Health Plan contribution if you and/ or your spouse use tobacco products

| DENTAL - DELTA DENTAL | | | | |
|--------------------------|---------------------------|-------------------------------|--|--|
| | Base Dental Plan Premiums | Enhanced Dental Plan Premiums | | |
| Participant Only | \$33.05 | \$53.39 | | |
| Participant + Spouse | \$65.99 | \$106.59 | | |
| Participant + Child(ren) | \$72.24 | \$108.69 | | |
| Participant + Family | \$105.18 | \$161.91 | | |

| VISION - METLIFE | | | |
|--------------------------|------------------|--|--|
| Coverage Level | Monthly Premiums | | |
| Participant Only | \$6.79 | | |
| Participant + Spouse | \$13.61 | | |
| Participant + Child(ren) | \$11.53 | | |
| Participant + Family | \$18.99 | | |